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M e m o r a n d u m

To: Ron Brown, Administrator
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Date: April 6, 2012

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From: Operation Guardians
Bureau of Medi-Cal Fraud and Elder Abuse - Sacramento
Office of the Attorney General

Subject: Operation Guardians Inspection

The Operation Guardians team conducted a surprise inspection of Yuba Skilled Nursing Center in Yuba City, on February 21, 2012. The following summary is based upon the team's observations, plus documents and information provided by the facility.

SUMMARY OF RESIDENT CARE FINDINGS:

1. The review of the medical chart for Resident 11-08-01 indicated the resident's original date of admission to the facility was 11/28/11 for rehabilitation following a fractured femur. The current nurse's notes reported the resident had just been re-admitted to the facility on 1/18/12 but it was not clear why the resident had been hospitalized. The "Nursing History and Admission Notes," completed by the nurse on 1/18/12, indicated the resident's diagnosis was "left femur fracture." The team nurse reviewed the Admission Face Sheet and determined the form had not been updated by the facility since readmission with any new diagnosis. The team nurse then reviewed the Care Plan and found there were no new concerns/problems other than identifying the resident's previous medical diagnosis from the Face Sheet. The team nurse was able to locate a physician's progress note dated 1/15/12. This note indicated the resident was admitted to the hospital to rule out **AMS**- an acronym that is not familiar to the team, but might be interpreted as **altered mental status**? The note also indicated the resident was positive for a urinary tract infection (UTI) and a cerebral vascular accident (CVA) had been ruled out. It was unclear from the facility's new admission documentation what acute symptoms the resident was having prior to her hospitalization. Due to the facility's inadequate documentation, the team could not determine if the resident was receiving the appropriate nursing care to meet her health care needs.

Additionally, the treatment authorization record (TAR) stated the resident had a thigh wound from the original hip surgery and the physician ordered wound care twice a day (BID). According to the February, 2012 TAR, the resident had only received **BID treatments nine (9) days during 2/1/12- 2/21/12.** The physician had ordered the nurses to monitor the left thigh wound daily for signs and symptoms of infection. **The monitoring was not completed by the nurses on 2/2, 2/5, 2/12, 2/14 and 2/18. No wound care or assessment for signs and symptoms of infection were completed on 2/20/12.** According to the TAR, the resident was also **not** receiving skin treatment as ordered **every shift** to a *"non-blanchable"* area on the buttocks. This failure of nursing care was evident by the missing nursing initials/blank areas on the TAR form.

Because of the lack of documentation, it appears the facility nurses were not appropriately assessing the resident's previous facility medical chart, and reviewing the information received from the hospital to accurately implement an appropriate care plan when the resident was returned to the facility. This lack of documentation and continuity of care can jeopardize the resident's quality of care. The team's nursing review revealed an absence of wound care, wound monitoring, and skin treatment by the facility's nursing staff. These are situations that may indicate possible neglect.

2. Resident 11-08-02 was observed lying in bed and appeared to have contractures to the left arm, wrist and hand. There was no splint applied to the arm or roll cloth inside the palm of the hand. Review of the resident's medical chart showed the resident was admitted to the facility on 1/18/08 with a Cerebral Infarction. A secondary diagnosis on 7/15/10 indicated the resident had hemiplegia/hemiparesis. There was no documentation in the resident's Care Plan showing a plan had been implemented to prevent the development of contractures. There was no physician order for rehabilitation, or for the resident to receive the rehabilitation nursing assistant program. Therefore, review of the chart revealed the resident had developed the contractures at the facility but there was no plan in place to prevent this condition from occurring or for treatment.

The "Physician Order For Life Sustaining Treatment" POLST - was signed by the resident's brother and the resident was a *"do not resuscitate"* (DNR). The team could not find any documentation that the brother had any legal authority to sign the POLST form. According to the admission document in 2008, the resident was his own responsible person. There was no diagnosis on the FACE sheet stating the resident lacked capacity. According to the chart documentation as reviewed, this resident's brother did not have the legal authority to sign this resident's POLST form.

The FACE sheet also indicated the resident was a US Army Veteran. There was no documentation in the chart the resident had been connected to any Veteran services.

3. Documentation presented by the facility indicated there was a high incidence of resident falls, with the same residents falling multiple times. Upon further review, it appears nursing staff were not implementing appropriate fall prevention plans for these residents. Care plans were not appropriately written to address these issues. Many of the residents were being transferred repeatedly to the hospital for falls that may have been preventable. Additionally, many falls were not recorded on the incident/accident logs.

4. Review of the residents' Treatment Authorization Records (TARs) and wound care logs, showed the facility had a high incidence of acquired pressure ulcers. By reviewing the wound care log, it was noted that wounds were identified as being on residents' sacrum, coccyx, heels, ear lobes, and trochanters.

5. The residents appeared unkept. Residents were observed with worn and soiled clothing. Male and female residents appeared to be in need of basic grooming and bathing. These are residents' rights and personal hygiene issues.

6. Many residents were observed with their water receptacles out of reach. This can place the resident at risk for dehydration.

FACILITY ENVIRONMENTAL OBSERVATIONS:

1. During the walk-through of the building, the OG team observed maintenance and structural issues. Areas of concern included decomposing walls at the floor level, uneven floor surfaces, peeling paint throughout the facility, non-functioning water fountains, and heavily soiled floors, baseboards and doors. It appeared the long-term care area of the building needed far more work than the rehabilitation section.

2. Resident call lights were observed to be illuminated for extended periods of time before the facility staff attended to the resident's needs.

5. Several resident rooms did not have the name of the resident on the door. These residents had been residing at the facility for several weeks. This is a safety issue. It is necessary for facility staff to accurately identify the residents and residents need to be able to locate their room.

6. The water fountains located by the kitchen and Central Supply Room were not functioning. This does not allow the residents to maintain hydration as needed. The water fountain located by the kitchen was soiled with a tan colored thick substance.

7. Unmarked urinals and pink basins were observed in resident rooms throughout the facility. This is a health and safety issue, as well as an infection control issue.

8. The resident residing in Room 304 C had the head of his bed positioned directly against the peeling paint on the wall. This could be a health hazard.

9. The shower room located across from Central Supply was observed with mold and feces (brown substance) on the floor. The shower room located by the Rehabilitation Department was also observed with a soiled floor. And the linen closet loated by Room 308 had a heavily soiled floor.

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ADMINISTRATIVE OBSERVATIONS:

1. It appeared that the facility's procedure is to close residents' charts when a resident is transferred to the hospital. The residents would return within the bed-hold time period, but the facility would complete all the admission paperwork again, along with the other necessary disciplines to repeat their assessments. This practice seemed to be a time consuming procedure, thus taking time away from resident care and possibly jeopardizing the continuity of care for the resident.

2. The team's observations of the facility's activities were that they were not structured to benefit all residents' needs. The only activity observed during the team's inspection time was "coloring in books" which was only attended by approximately seven residents. Several residents were observed in need of constant redirection by the staff as they were not engaged in the activity.

STAFFING:

Based on the records provided by the facility, staffing levels were not compliant with the 3.2 hours per resident day (hprd) on **two of the six** days randomly reviewed**. The average hprd was 3.34 hours.** Providing the minimum required number of nursing hours is not always adequate to guarantee a quality level of care for the residents. The team was concerned with the amount of staffing hours, considering the high incidence of acquired pressure ulcers and the resident falls.

CONCLUSION:

Please be advised that this is a summary of information available to us at this time. Should further information develop from the efforts of Operation Guardians, we will notify you at the appropriate time.

The Operation Guardians inspection does not preclude any Department of Health Services complaint or annual visits, any law enforcement investigation or other licensing agency investigation or inspections, which may occur in the future. A copy of this report is being forwarded as a complaint to the Department of Health Services. This inspection does not preclude any further Operation Guardians unannounced inspection.

We do not require that you submit a plan of correction regarding the findings of the Operation Guardians inspection. However, at some future time, the contents of this letter may be released to the public.

We encourage your comments so they can be part of the public record as well. If you have any questions or any comments, please contact Cathy Long NEII, at 1425 River Park Drive, Sacramento, California 95815, phone: (916) 274-2913 or Peggy Osborn at (916) 263-2505.

Operation Guardians
Physician's Report
Kathryn Locatell, MD
April 9, 2012

Yuba Skilled Nursing Center
February 21, 2012

The care of 15 current and former residents was reviewed. Systemic problems in the nursing department included the listing of inaccurate diagnoses, poor end-of-life care, avoidable dehydration and inadequate fall prevention. There did not appear to be adequate nursing monitoring in a number of cases, leading to potentially preventable hospitalizations. Discharge planning needs improvement.

I. Inaccurate diagnoses.

The diagnoses listed on resident face sheets were notably inaccurate. This is a problem because staff in all disciplines, but in particular nursing, rely on this information, and the face sheet is an important source for staff to refer to if they are unfamiliar with the resident. In an emergency, the ability to find diagnosis information rapidly is critical. For example, Resident 11 has a diagnosis of "hypokalemia" listed on her face sheet, which is the medical term for low potassium level in the blood. But this resident had actually experienced a high potassium level ("hyperkalemia"), a common and potentially life-threatening complication in persons receiving kidney dialysis such as Resident 11. It is very important that staff are aware that the resident has had this condition and is at risk for it in the future and the correct diagnosis should have been listed. The admitting orders as transcribed by a nurse state that one of her diagnoses was "hypeorkalemia" [sic], indicating that the nurse was not aware of her true diagnosis or how to spell it. Resident 11's list of diagnoses also did not include severe constipation, which was the precipitating cause for the surgery she had prior to admission. In another example, the primary diagnosis listed for Resident 14 is "cerebral palsy"; however, this resident is 90 years old and if she did have cerebral palsy at birth, it certainly isn't a problem for her now. Ensuring that each of a resident's diagnoses is listed and accurate is also important for the delivery of good nursing care. Licensed nurses, while administering medications, must know what each drug is used for in order to monitor for effectiveness, for example.

II. End-of-life care.

In two recent cases, nurses failed to provide adequate monitoring during the residents' last hours. Resident 9 died on 2/19/12. It was noted that she had developed a suspected deep tissue injury (pressure ulcer) on her sacral area two days before her death. Although this was a significant change in her condition, as well as one likely to cause her significant pain, there was a total absence of narrative charting by nurses in those two

days, representing a gap of almost 40 hours. Nurses should have been assessing and documenting their findings on a shift-by-shift basis, addressing both the appearance of the pressure ulcer and the resident's comfort level.

Resident 12, who died on 2/9/12, was dying from lung cancer that was metastatic to his brain and spine. There was evidence that his pain control was poorly controlled as of six (6) days before his death, and he had suffered an avoidable fall from the toilet five (5) days before death. Yet nurses failed to document any observations concerning his condition in the narrative notes for more than 48 hours prior to the time he was found dead. At a minimum, nurses should have been charting on an every-shift basis for three (3) consecutive days after the fall, yet failed to do even this. Likely both Resident 9 and Resident 12 did not receive adequate nursing care or pain control in their final days.

III. Avoidable dehydration.

Resident 8 was sent to the hospital on 12/6/11 after laboratory testing done at the facility the day before showed significant dehydration. The resident's sodium and blood urea nitrogen levels were significantly elevated, and she had been losing weight. She was suffering from Alzheimer's disease, and following firve (5) days in the hospital, her condition had declined to the point that she was judged to be terminal; she died within two (2) months. There is no evidence in the resident's chart that nursing staff were monitoring her intake of food and fluids during the days prior to her transfer to the hospital. In fact, the most recent weekly summary dated 12/2/11 states that she was consuming "80-100% of all meals with adequate [oral] fluids", which is very unlikely to have been true. The nurse who documented notifying her physician of the lab reports on 12/6 wrote that she was being sent to the hospital for "congestive heart failure" and a diagnosis of "chronic kidney failure". However, she clearly did not show any signs of congestive heart failure at the time, and the elevated sodium level could only have been caused by dehydration. It appears that the nurse was attempting to obfuscate the true reason for the resident's deterioration, and when she returned, the face sheet listed "end stage renal disease" (untrue) and "hyperosmolality" (true) but not dehydration. The diagnosis for hospice was "failure to thrive". Based on the failure of nursing staff to monitor her intake of fluids and recognize signs of dehydration before it became severe, it is likely that any such failure to thrive was caused by deficient nursing care and was avoidable.

Resident 13 has also been declining in weight and had laboratory evidence of dehydration fie (5) days before our inspection. He is also suffering from dementia, and Parkinson's disease, and has had progressive difficulty swallowing, and has been receiving a diuretic medication which increases the risk he will become dehydrated. There is no evidence in the nursing documentation that staff were monitoring his intake of fluids or conducting hydration assessments. The resident is at high risk for becoming avoidably dehydrated.

Resident 4 is the one resident the facility identified as being at risk for dehydration on the day of our inspection. The resident was admitted to the facility in late December from an acute care hospital and was supposed to be receiving weekly weights. However, an order

entered in his charts says not to weigh him for the week of 1/8/12 "due to possible norovirus". It is unclear whether there was an outbreak of diarrheal illness in the facility at the time or not, but Resident 4 was noted to have "contracted the stomach flu virus" according to a certified nursing assistant's entry for the night shift of 1/8. He was sent back to the hospital 3 days later, critically ill with diarrhea, vomiting, decreased urine output and a blood pressure of 57/36. A hospital record present in his chart states that he presented with among other things, hypovolemia and acute chronic renal failure, both of which are indicative of dehydration. Review of the nursing notes for the days prior to his transfer shows no evidence that nurses were monitoring his intake of fluids or conducting hydration assessments. There appears to have been a delay in recognizing how ill Resident 4 was becoming until his condition had become critical on 1/11/12.

IV. Inadequate fall prevention.

The size and physical layout of the facility is such that careful planning is needed for residents at risk for falling: staff may be at some physical distance when they are needed to supervise the resident at risk. This means that careful attention to planning for fall prevention is essential. However, in the case of at least one resident reviewed, Resident 1, the facility failed to plan and implement planned interventions to prevent her from falling. She fell and broke her right ankle on 1/15/12.

As of her comprehensive assessment (Minimum Data Set) dated 8/28/11, Resident 1 was nonambulatory but required only supervision for transfers from bed to chair. She fell for the first time on 10/16, while attempting to transfer herself. According to an interdisciplinary fall review on 10/17, the plan was to advise the resident to use her call light for assistance when she desired to transfer, and to have physical therapy evaluate her for "proper transfer technique". I did not find any physical therapy notes or evaluations in her chart thereafter.

She fell again on 12/24, and again was reviewed by the interdisciplinary team; however, it was not noted that the plan after the last fall for a physical therapy evaluation was not carried out, and again the IDT recommended reminding her to use the call light for assistance. The third fall occurred on 12/31; again the IDT recommended a physical therapy evaluation ("screen") but no physical therapy notes are found for this time frame. The fourth fall which resulted in the ankle fracture, like the preceding falls, occurred when the resident was attempting a self-transfer. After the application of a splint and later a cast, the resident was not to bear weight on the right foot, and she developed a pressure ulcer of the left heel. Her current care plan says she is independent with transfers, whereas she clearly is more dependent now than she was before she broke the ankle.

I asked the physical therapist about whether Resident 1 had in fact been "screened" after the earlier falls since no documentation was present in her chart. The therapist told me that she would "get them in there," meaning her chart, but was unable to produce the documentation for me to review. It seems unlikely that any such screening did take place, as there were no changes to her plan of care and no evidence that her abilities to

self-transfer changed. This resident continues to be at high risk for falling and suffering further avoidable injuries from falling.

Resident 3 was admitted to the facility on 2/15, with diagnoses including stroke and a wrist fracture from falling. Two days after admission, Resident 3 fell to the floor from her bed. She was known to be at high risk, but the care plan addressing her risk did not include basic interventions such as the provision of toileting services, personal alarms or reinforcing her safety awareness. The IDT review after Resident 3's fall indicates that the plan was to place half-rails on her bed and that "alarms [were] working" at the time of her fall. Without additional efforts to ensure that planned interventions are carried out, and to devise additional interventions to protect Resident 3's safety, the resident remains at very high risk for falling and becoming injured.

V. Poor nursing monitoring.

As noted above, there were instances when residents in need of frequent monitoring by licensed nurses did not receive it as evidenced by gaps in the narrative nursing notes. In some cases reviewed, although nurses wrote narrative entries, frequently the entries were devoid of meaningful information and constituted rote charting. Rote charting, the practice of entering stock phrases that do not speak to the individual resident's condition or care needs, gives the impression that nurses are assessing the resident while soon-to-become obvious changes in resident status are not documented and it turns out that the resident was in need of medical attention. For example, the nurse who documented that Resident 8's oral intake was adequate did not document an assessment of her hydration status; she turned out to have become dehydrated during the time frame covered by the nurse's charting. Rote charting is also indicative of poor supervision, since most supervisory nurses will agree that entries without meaningful information about the resident do not constitute evidence that the resident was actually assessed and monitored.

When rote charting takes the place of meaningful entries, nurses may mistakenly rely on it and fail to follow up with careful clinical observation. Then, the decline in the resident's condition goes unnoticed until the deterioration is severe. The failure to carefully observe and monitor residents whose conditions were changing was noted in several residents reviewed. The end result, as in the cases of Residents 4, 6, 7, 8, 9 and 12, is that action is delayed and residents are harmed.

VI. Discharge planning.

I did not find evidence in many of the residents reviewed that efforts are made toward planning for the resident's discharge. This was especially the case for residents admitted for Medicare-paid skilled nursing, many of whom lived independently in the community prior to needing hospitalization. The standard for such residents is that discharge planning begins on admission to the nursing home, with frequent updating of plans, based on the resident's progress with therapy and nursing care. For example, there were no entries concerning Resident 3's discharge plan beyond an assessment stating that it was "uncertain at this time". Resident 10, who has been living at the facility for many

months, is fully oriented ("x 4"), independent in all of her activities of daily living and does not appear to be in need of nursing facility care. According to a team member's interview with her daughter, Resident 10 was at the facility to "make sure she takes her meds". There was no plan for discharge found in the record.

In summary, conditions at this home at the present time are concerning, with poor nursing monitoring that has resulted in residents experiencing avoidable falls, dehydration, clinical deterioration and poor end-of-life care. Disorganization has led to inaccurate and missing diagnoses listed in resident charts.